

Subject: Responses to Comments
From: "Blenkush, Nathan" <[log in to unmask]>
Reply To: Teaching Behavior Analysis <[log in to unmask]>
Date: Thu, 15 Jul 2021 16:42:57 +0000
Content-Type: multipart/mixed
 text/plain (11 kB) , text/html (37 kB) ,
Parts/Attachments: Bibliography.pdf (69 kB) , Blenkush (2021) CSS 173.pdf (534 kB)

Apologies for the long post:

Marshall,

For each individual case, informed consent (which can be revoked at any time) is a pre-requisite. The patient must go through a substituted judgement process. For a more detailed discussion see: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2733506/>

Please see the following list of safeguards:

Parental Consent. The student's clinician will request an in-person meeting with the parent or guardian to discuss the possible addition of supplementary aversives to the student's treatment program. No aversive is employed without prior, written informed consent from the parent or guardian. Consent forms are reviewed and re-signed every year. Consent may be revoked by the parent at any time.

Individualized Education Program (IEP) Team Meeting. For school aged students, the local school district holds an IEP team meeting to discuss what the student needs in order to obtain a Free Appropriate Public Education (FAPE). The parent is a member of the IEP team. At that meeting, the team will discuss the potential benefits of adding an aversive intervention to the student's IEP. Aversives cannot be used unless they included in the student's IEP.

Court Appointed Attorney. Once the use of aversive interventions is added to the student's IEP, the individual court process in Massachusetts can then be started. Typically, JRC initiates the process by filing a guardianship petition and proposed treatment plan with a Massachusetts Probate Court, and a request for a hearing. The Court appoints an attorney to represent the interests of the student/client, which are separate and apart from those of JRC or of the parent. The attorney hires his/her own expert psychologist, at state expense, to evaluate the student and advise the attorney as to what position the attorney should take on the proposed treatment plan, including the use of aversives, with the student in question.

Court Hearing. JRC submits a detailed proposed treatment plan to the Court. The Court must decide: (1) whether or not the student is competent to make his/her own treatment decisions; and (2) if competent, would he or she have chosen the treatment? The Judge makes the ultimate determination whether or not aversives will be approved for the individual's treatment plan.

Reports to the Court. An individualized quarterly report on the use of the aversives for each student is sent to the court, parent, and sending agency. The report includes the number of applications given, the behaviors for which the aversives were used, the progress the student is making behaviorally and academically, and the plan to fade the individual from the aversives.

Opportunity for Opposing Counsel to Object to the use of Aversives at any Time. The opposing counsel can object to the treatment plan and seek to change or remove the

plan at any time.

Opportunity for Parent to Withdraw Permission for Aversives at any Time. If a parent or legal guardian withdraws his/her consent, JRC ceases use of the aversive immediately, whether or not JRC still has a court authorization to use aversives with that student or not.

Treatment Plan Reviews. The treatment plan is reviewed by the Probate Court on a yearly or more frequent basis.

Annual IEP Meetings. The IEP Team meets each year. At that meeting, the Team will discuss the need for continuing the aversive intervention.

Case Conferences. For students who have had a treatment plan that includes aversive interventions for three years, the case is reviewed by independent clinicians, to determine the need for continued treatment.

Parent Agency Website. The parents and the sending agency have the ability to monitor the student's treatment through a secure website as frequently as they wish. This means that the parent can see the number of aversives administered each day, what behaviors they were administered for, and the progress the student is making.

Certification of JRC by the Massachusetts Department of Developmental Services (MA DDS) to use Level III aversives. JRC goes through periodic rigorous reviews (a minimum of every two years) by the MA DDS to remain certified to use "Level III" procedures. Level III procedures include the use of aversives.

Medical Approval. A physician examines each student whose treatment plan includes supplementary aversives. The Physician must sign an approval indicating that the treatment is not contraindicated by the student's medical condition if aversives are to be employed. Depending on the student's medical history and condition, the student may also be examined for any contraindications by a psychiatrist, neurologist, and/or cardiologist.

The Human Right Committee. This committee, which is composed of volunteer members from the community, JRC parents and others, must approve the use of aversives on an individualized basis for the student in question prior to their use.

The Peer Review Committee. This committee, which is composed of clinicians other than the student's own clinician, must also approve of the use of aversives on an individualized basis for each individual student prior to their use.

Design and Oversight of each Student's Program by a Qualified Clinician. A qualified clinician with doctoral level training in psychology and experienced in applied behavior analysis designs each treatment plan based on the individual needs of the student, designates which behaviors will be selected for treatment with aversive interventions, and oversees the implementation of the plan. The clinician must authorize any change in treatment. The clinician sets limits on the number of aversives that can be used before the clinician is notified. The clinician observes and meets with the student at least weekly and more frequently at the start of the treatment plan and at any time treatment is not progressing well.

Nursing and Medical.

Direct care staff do body checks on all students each morning and evening.

All applications of the aversive are reported to nursing staff who do a body check on the student within 24 hours. The electrode site is checked each hour, when the electrode is rotated, and also after each application. Each student receives a complete medical examination at least annually and is

After each application, each student receives a complete medical examination at least annually, and is referred to a medical specialist if needed. Nursing care is provided on a 24/7, round-the-clock basis.

All classrooms and residences are monitored on a 24/7 basis from a central location by means of a digital video monitoring system. All classrooms and residence are covered by video cameras and microphones. Experienced staff members monitor activities in both the school and residences, from a central location at the JRC administration building, using the internet.

Tight Control over the Number of Applications. The number of applications of the skin shock that are used with any student who has skin shock in his/her treatment plan is kept low. The average student receives less than one application per week. If more than 1 application in any 24 hour period is required, the student's clinician sets the number which may be administered before he or she is notified and gives further approval. This number can be no greater than 10.

Data Collection and Review by Clinicians and Parents. Every application of an aversive is documented on the student's daily recording sheet and transferred to daily, weekly and monthly charts which are immediately available to the student's clinician (through a database that is available through networked software) and to the parents and placing agency (through a Parent/Agency Website), enabling clinicians, parents and agency officials to know exactly how many applications are made, for what behaviors, and with what results.

Regarding Lou's comments:

Lou writes that contingent skin shock is "incredibly abusive" and indicated it is "...often misrepresented to families and caregivers who don't understand and aren't advised of the depth and nature of the field of Applied Behavior Analysis." These statements are false. I suggest that such statement should not be made without actually knowing the patient, their treatment history, their risk of injury, the internal process utilized at JRC, and all their unique individual characteristics. Indeed, the attorney that represents the patient, their consenting parent/guardian, independent outside mental health expert, and probate court Judge look at these factors when forming opinions about how to proceed.

For some of our patients, contingent skin shock was the most significant and important treatment even of their life. For example, consider the following (the information below is public and JRC has consent to share it):

<https://myemail.constantcontact.com/A-New-Era-for-Erica-at-Judge-Rotenberg-Center.html?soid=1117421862105&aid=GkatrQ8VxsM>

https://myemail.constantcontact.com/A-Brighter-Future-for-Gideon-at-the-Judge-Rotenberg-Center.html?soid=1117421862105&aid=brkQOq6N_pc

False statements have the potential to interfere with the benefits experienced by current and future patients.

I personally review the literature, potential risks and benefits, and the entire treatment process with each new family that is pursuing a Level III behavior plan. These families have a complete understanding of what is going on with their child and what treatments are available, it is their lived experience. They are the ones who received the restraint notifications, visited the ED on dozens of occasions, called the police because of their child's behavior, reviewed rejection letters from treatment providers, visited their child in jails and psychiatric hospital, and awakened in the middle-of-the-night and listened to calls describing all manner of crises. They are consumers of behavior analytic services and have often encountered behavior analysts during early intervention, special education, day treatment, residential treatment, hospitalization, and through consults.

The decision to use contingent skin shock is not predetermined and includes numerous checks and balances (referenced above) including informed consent. Contingent skin shock is, perhaps, the most

regulated treatment. Over the last 20 year, less than 20% of all JRC admission have received contingent skin shock. Currently, less than 18% have approved plans.

Yadollahikhales et al. provides detailed information on 4 patients, not one. The attached paper Blenkush & ONeill (2021) describes 173. I also attached a bibliography for anyone interested.

Cons are considered through individual risk-benefit analysis. Regarding generalization and the prosthetic nature of treatment for some, we write the following in Yadollahikhales et al.:

While this is true in some cases, one must consider the nature of the problem. CSS is only considered for extraordinarily severe and treatment refractory problem behaviours that have caused extreme harm and continue to pose serious threat. In such cases, a treatment that reduces or eliminates such behaviours is highly valued. As with some patients receiving GED, many treatments for illness or dysfunction in medicine are prosthetic in nature as well. For example, treatments that must be maintained to manage or prevent relapse of symptoms include insulin for diabetes, antiarrhythmic and antihypertensive drugs for cardiovascular disease, proton pump inhibitors for reflux disease, corrective eyewear, psychopharmacological interventions and various behavioural interventions. (p.7)